OHS/CAD-200 (5/03)

State of Michigan Michigan Department of Consumer & Industry Services

Bureau of Health Services

Complaint and Allegation Division P.O. Box 30670 Lansing, MI 48909-8170

	Office Use Only	
File #		

Date

ALLEGATION FORM

Authority: Public Act 368 of 1978, as amended. Completion: Voluntary Penalty: None

I wish to complain against the individual named below. I understand that this agency and the Licensing Board do not assist citizens seeking return of their money or other personal remedies. I am, however, submitting this information so that it may be determined if licensing action against this practitioner should be considered.

Instructions: Print legibly or type information. Complete all sections of this form. Sign at the bottom. Return the white copy to the address at above. Retain the canary copy for your records.

address at above. Reta	ain the canary copy	for your records.					
	formation About Yo	u		Complaint Filed Against			
Your Name			Practiti	Practitioner's Name			
Street Address			Street /	Street Address			
City			City	City			
State	Zip Code	County	State		Zip Code		
Patient's Name			Practiti	Practitioner's Telephone Number ()			
Your Telephone Number Home () Work ()			Treatm	Treatment/Incident Date			
Check one: Allopathic Physician (National Chiropractor Counselor Dentistry Emergency Medical Se	ervices Personnel	☐ Marriage & Family☐ Nurse (RN or LPN☐ Nursing Home Ad☐ Nurse Aide (CENA☐ Occupational Ther	l) ministrator A) rapist	☐ Optometrist☐ Osteopathic Physicia☐ Pharmacist☐ Physical Therapist☐ Physician's Assistan	☐ Sanitarian ☐ Social Worker		
Is there court action pending? Enter your attorney's name ☐ Yes ☐ No			this inform	May we release your name and this information to the practitioner? ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No			
	oncerns (who, wh	at, when, where, how	w, etc Use	additional sheets if ned	essary).		

Signature